WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Patient Name_____ Date _____
Last, First MI

Sex:___M ___F Status: Married ___ Single ___ Child ___ If patient is a minor, give name of parent or legal guardian_____

Social Security # _____Driver License _____Birth Date: _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Address _____ City _____ State ____ Zip _____

E-mail:_____

Spouse or Responsible Party Information

The following is for: ___the patient's spouse ___ the person responsible for payment

Name _____ Sex: ___M ___F Married ___ Single ___ Child ___
Last, First MI

Social Security # _____Driver License _____Birth Date: _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Address _____ City _____ State ____ Zip _____

Employment Information

The following is for: ___the patient ___ the person responsible for payment

Employer Name _____ Occupation _____

Address _____ City _____ State ____ Zip _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ___yes ___no
Last, First MI

Insured's Birth Date _____ SS # _____ID # _____ Group # _____

Insured's Address _____ City _____ State ___ Zip _____

Insured's Employer Name _____ Patient's relationship to insured ___ Self ___Spouse ___Child

Insurance Plan Name and Address _____

Secondary

Name of Insured: _____ Is insured a patient? ___yes ___no
Last, First MI

Insured's Birth Date _____ SS # _____ID # _____ Group # _____

Insured's Address _____ City _____ State ___ Zip _____

Insured's Employer Name _____ Patient's relationship to insured ___ Self ___Spouse ___Child

Insurance Plan Name and Address _____

Referral Information

Whom may we thank for referring you to our practice? __ Another patient, friend __ Another patient, relative

__ Dental Office __Yellow Pages __Post Card __Other:_____

Name of person or office referring you to our practice _____

PLEASE COMPLETE BOTH SIDES

Dental History

Reason for this visit _____ Date of Last Dental Visit _____
Former Dentist _____ Date of Last Dental X-rays _____
Why are you changing dentist? _____

Check if you have had problems with any of the following:

□ Bad Breath
□ Bleeding gums
□ Clicking or popping jaw
□ Food collection between teeth
□ Grinding teeth
□ Loose teeth or broken fillings
□ Periodontal treatment
□ Sensitivity to cold or hot
□ Sensitivity to sweets
□ Sensitivity when biting
□ Snoring
□ Sores or growths in your mouth

Are you dealing with any significant dental issues at this time? Yes / No
Are you currently in pain? Yes / No
Do you like your smile? Yes / No
Would you like whiter teeth? Yes / No
Have you ever had a difficult problem associated with any dental treatment? Yes / No

Health History

Physician's Name _____Date of Last Visit _____

Have you had any serious illnesses or operations in the past two years? □ Yes □ No
If yes, please explain _____

Are you now under the care of a physician? □ Yes □ No If yes, please explain _____

List any medications you are taking _____

Do you have any of the following? Please check those that apply:

ALLERGIES:

□ Allergy: Aspirin
□ Allergy: Codeine
□ Allergy: Latex
□ Allergy: Local Anesthetics
□ Allergy: Penicillin
□ Allergy: Sulfa
□ Other _____
_____
□ Abnormal Bleeding
□ Alcohol/Drug
□ Anemia
□ Arthritis
□ Artificial Bones/Joints/Valves
□ Asthma
□ Back Problems
□ Blood Disease
□ Cancer/Chemotherapy
□ Chemical Dependency
□ Colitis
□ Congenital Heart Defect
□ Diabetes
□ Difficulty Breathing
□ Dizziness/ Fainting
□ Emphysema
□ Epilepsy
□ Frequent Headaches
□ Glaucoma
□ Hay Fever
□ Head Injuries
□ Heart Attack/Surgery
□ Heart Disease
□ Heart Murmur
□ Hemophilia
□ Hepatitis
□ Herpes/Fever Blisters
□ High Blood Pressure
□ HIV+/AIDS
□ Jaundice
□ Kidney Disease
□ Liver Disease
□ Low Blood Pressure
□ Mitral Valve Prolapse
□ Nervous Disorders
□ Pacemaker
□ Pregnancy:
Due Date:_____
□ Prior use of Phen Fen
□ Psychiatric Problems
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatic Fever
□ Scarlet Fever
□ Seizures
□ Sickle Cell Disease/Traits
□ Sinus Problems
□ Stroke
□ Thyroid Problems
□ Tobacco Use
□ Tuberculosis
□ Ulcers
□ Venereal Disease
□ Other _____
_____

ASSIGNMENT AND RELEASE

The information provided is accurate and complete to the best of my knowledge and is only for my treatment, billing and processing of my insurance for benefits which I am entitled. I will not hold Dr. I. Vorobchevici and any member of her staff responsible for any errors or omissions I may have made in the completion of this form. I, the undersigned, assign directly to my dentist all benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance and that the payment is due at the time the treatment is done.** A service charge of 1.5% per month (18 % per annum) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date. Any additional fees for collections will be the responsibility of guarantor at a rate of 41%.I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

Please Initial X_____. I hereby authorize Dr. Vorobchevici's Office to release all information necessary to secure payment of benefits and I authorize the use of my signature on all my insurance submissions whether manual or electronic.

I give my consent for initial treatment which may include exam, x-rays, impressions, photos or emergency treatment as described to me by Dr. Vorobchevici.

By my signature below I am also acknowledging that I have read and received a copy of the Dental Materials Fact Sheet dated 5/04 and the office's Notice of Privacy Practices.

Failed / broken appointments without 24 hour notice - $ 50 charge.

SIGNATURE: _____ **Date:**_____

MINOR/CHILD CONSENT

I being the parent or guardian of _____do hereby request and authorize the staff of Dr. Vorobchevici's Office to perform necessary dental services, including but not limited to X-Rays, administration or local anesthetics or nitrous oxide sedation which are deemed advisable by the dentist, whether or not I am present at the actual appointment which is rendered.

SIGNATURE OF PARENT/GUARDIAN: _____**Date:**_____